BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	)	
Jay Allwyn Hendrickson, M.D.	)	Case No. 800-2014-007164
Physician's and Surgeon's Certificate No. G 83722	)	
Respondent	)	

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on October 18, 2018.

IT IS SO ORDERED: September 18, 2018.

MEDICAL BOARD OF CALIFORNIA

Ronald H. Lewis, M.D., Chair
Panel A

XAVIER BECERRA
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ALEXANDRA M. ALVAREZ
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **JAY A. HENDRICKSON, M.D.** **2350 East Bidwell St.** **Folsom, CA 95630** **Physician's and Surgeon's Certificate No. G 83722** Respondent.	Case No. 800-2014-007164 OAH No. 2017061081 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Megan R. O'Carroll, Deputy Attorney General.

2. Respondent Jay A. Hendrickson, M.D. (Respondent) is represented in this proceeding by attorney Robert B. Zaro, Esq., whose address is: 1315 "I" Street, Suite 200, Sacramento, CA 95814.

3. On or about May 2, 1997, the Board issued Physician's and Surgeon's Certificate No. G 83722 to Jay A. Hendrickson, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2014-007164, and will expire on September 30, 2018, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2014-007164 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on August 28, 2017. Respondent timely filed his Notice of Defense.

5. A copy of First Amended Accusation No. 800-2014-007164 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2014-007164. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in the First Amended Accusation No. 800-2014-007164, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the First Amended Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the First Amended Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent further agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition for revocation of probation is filed against him before the Medical Board of California, all of the charges and allegations contained in the Accusation No. 800-2014-007164, shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding, or other licensing proceeding involving Respondent in the State of California.

12. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 83722 issued to Respondent Jay A. Hendrickson, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully

complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

8. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than

30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

13. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Robert B. Zaro, Esq.. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 6/5/2018

JAY A. HENDRICKSON, M.D.
Respondent

I have read and fully discussed with Respondent Jay A. Hendrickson, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 6/5/18

ROBERT B. ZARO, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 6-7-18

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

MEGAN R. O'CARROLL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2014-007164

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **Jay A. Hendrickson, M.D.** **2350 East Bidwell St.** **Folsom, CA 95630** **Physician's and Surgeon's Certificate No. G 83722,** Respondent.	Case No. 800-2014-007164 OAH No. 2017061081 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about May 2, 1997, the Medical Board issued Physician's and Surgeon's Certificate No. G 83722 to Jay A. Hendrickson, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2018, unless renewed.

JURISDICTION

3. This First Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not

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apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

5. Section 2220 of the Code states:

"Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

"(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

"(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

"(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon."

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. At all times alleged herein, Section 3502[1] of the Code stated:

"(a) Notwithstanding any other provision of law, a physician assistant may perform those medical services as set forth by the regulations adopted under this chapter when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant.

"(b) (1) Notwithstanding any other provision of law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient specific orders from the supervising physician and surgeon.

"(2) The supervising physician and surgeon shall be physically available to the physician assistant for consultation when such assistance is rendered. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

"(c) (1) A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

"(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

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[1] Business and Professions Code section 3502 was amended by Stats. 2015, Ch. 536, Sec. 2. Effective January 1, 2016.

"(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow up care.

"(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

"(D) Protocols shall be signed and dated by the supervising physician and surgeon and the physician assistant.

"(2) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant. The physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

"(3) Notwithstanding any other provision of law, the Medical Board of California or board may establish other alternative mechanisms for the adequate supervision of the physician assistant.

"(d) No medical services may be performed under this chapter in any of the following areas:

"(1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof.

"(2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics.

"(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.

"(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Chapter 4 (commencing with Section 1600).

"(e) This section shall not be construed in a manner that shall preclude the performance of routine visual screening as defined in Section 3501."

8. At all times alleged herein, Section 3502.1 of the Code stated[2]:

"(a) In addition to the services authorized in the regulations adopted by the Medical Board of California, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

"(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

"(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

"(b) 'Drug order,' for purposes of this section, means an order for medication that is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to 'prescription' in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising physicians

[2] Business and Professions Code section 3502.1 was amended by Stats. 2015, Ch. 536, Sec. 3. Effective January 1, 2016.

and surgeons, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

"(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician and surgeon before it is filled or carried out.

"(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

"(2) A physician assistant may not administer, provide, or issue a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets standards, including pharmacological content, approved by the board. The education course shall be provided either by an accredited continuing education provider or by an approved physician assistant training program. If the physician assistant will administer, provide, or issue a drug order for Schedule II controlled substances, the course shall contain a minimum of three hours exclusively on Schedule II controlled substances. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established by the board prior to the physician assistant's use of a registration number issued by the United States Drug Enforcement Administration to the physician assistant to administer, provide, or issue a drug order to a patient for a controlled substance without advance approval by a supervising physician and surgeon for that particular patient.

"(3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

"(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name, address, and telephone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant and shall otherwise comply with the provisions of Section 11162.1 of the Health and Safety Code. Except as otherwise required for written drug orders for controlled substances under Section 11162.1 of the Health and Safety Code, the requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number, and if applicable, the federal controlled substances registration number of the physician assistant, and shall be signed by the physician assistant. When using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

"(e) The medical record of any patient cared for by a physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven days.

"(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA).

"(g) The board shall consult with the Medical Board of California and report during its sunset review required by Division 1.2 (commencing with Section 473) the impacts of exempting Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon to review and countersign the affected medical record of a patient."

FACTS

9. Respondent Jay A. Hendrickson, M.D. (Respondent) is subject to disciplinary action under section 2234, subdivision (b), in that he engaged in acts of gross negligence in his care and treatment of patients B.B and B.H. The circumstances are as follows:

10. Respondent operates a pain management practice with multiple locations in Northern California called Hendrickson & Hunt Pain Management Physicians, ("H&H"). The practice has multiple physicians and mid-level practitioners. Both physicians of the practice, Respondent and B. Kelly Hunt, M.D., supervise the mid-level practitioners.

Patient B.B.

11. Patient B.B. first established care with H&H in 2001.[3] The medical record contains a history and physical by Respondent, dated August 24, 2001, indicating that B.B. is a 59-year old woman referred to him for pain management with a chief complaint of low back pain. She rated her pain as 6/10. It indicated she had previously undergone a series of steroid injections and a laminectomy for back pain. It lists a medical history of hypertension, ulcers and cataracts. B.B. reported that she smokes a half a pack of cigarettes per day and has smoked for 25 years. Radiological tests showed bulging discs at multiple points of the spine and some degenerative changes and stenosis. She was diagnosed with degenerative disc disease. The treatment recommendation was to increase use of Oxycontin to 80 mg three times per day, to discontinue Vioxx, and to continue with aqua therapy and epidural steroid injections. She was scheduled to be seen again in 8 weeks.

12. At the next appointment in October the Oxycontin was increased to 120 mg four times per day, Neurontin was added to the regimen, and Respondent recommended trying medical branch blocks. B.B. reported her pain at 9/10. At the next appointment on December 14, 2001, B.B. continued to report 9/10 pain, but also said the Oxycontin was effective, and reported breakthrough pain. Norco was added, 10 mg 6 times per day and B.B. was directed to continue Physical Therapy and Tens unit.

13. At the next appointment on January 22, 2002, B.B. still reported a lot of pain, and Respondent increased the Oxycontin to 160 mg four times per day, with the Norco for breakthrough pain and Baclofen was added to the regimen. The plan was to try a medical branch block as a last resort to surgery. From this point on, B.B. was usually instructed to returned for

[3] Facts alleged outside of the statute of limitations are for informational purposes.

follow up appointments each month. On February 12, 2002, it is noted that B.B. will have surgery later that month. The pain medications remained the same. On March 28, 2002, B.B. reported having had a lumbar fusion of multiple vertebrae at U.C. Davis, and having a reduction in pain of approximately 60%. The Oxycontin was continued at the same rate, with the intention to wean down in the future once she has more time post operatively to recover.

14. At the May 9, 2002 appointment, B.B. reported even greater pain relief, with her pain noted to be 3/10, and increased activity. She reported titrating down her Oxycontin usage to 80 mg four times per day and Respondent recommended she reduce it to 40 mg to continue the titration. The diagnosis was still noted to be degenerative disc disease.

15. On or about or about June 7, 2002, B.B. began being seen primarily by Physician Assistants at H&H, supervised by Dr. Hendrickson. She reported increased pain in her leg and post operative pain. Pain was rated 4-5/10. The PA noted that B.B.'s medications were refilled at the same dose, but also that B.B. continues to take Oxycodone IR from her surgeon for breakthrough pain.

16. On or about July 8, 2002, B.B.'s Oxycontin, Baclofen and Norco were refilled, and it was noted that she is being prescribed Neurontin from her U.C. Davis surgeon. On August 9, 2002, B.B. noted that she discontinued her Neurontin herself because she did not think it was helping. She continued to have increasing post-operative pain. She requested another trial of injection therapy. Her medications were refilled.

17. By the Fall of 2002, B.B. continued to be seen at H&H, primarily by mid-level practitioners under the supervision of Respondent. Most of the chart notes during this time are co-signed by Respondent. During this time there was little change in B.B.'s condition and monthly chart notes show continued refills of Oxycontin, Baclofen and Norco. The November 2002, chart notes state that B.B. was considering another surgery. In December of 2002, B.B. had a nerve root block with fluoroscopy with H&H and another was tried in January of 2003. Over the course of her treatment with H&H, B.B. underwent numerous physical medicine procedures, with most providing little or no lasting pain relief.

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18. On or about February 11, 2003, B.B. had continuing low back pain, increasing, and noted no relief from the nerve block. She was on 80 mg of Oxycontin, four times per day, Norco 10 mg six times per day, and Baclofen 10 mg three times per day. On or about March 14, 2003, B.B. remained on the same medications and indicated she was considering having a Spinal Cord Stimulator implanted. There was no major change in April, and on May 29, 2003, the Oxycontin increased to 120 mg three times per day. The July 16, 2003, chart note indicated B.B. reported that the increase in Oxycontin helped her. B.B. was reported to still be considering possible spinal cord stimulator implantation or other procedures. Throughout the fall of 2003, B.B. remained similar in status and the chart notes are similar to previous appointments. The November 5, 2003, chart note indicated that B.B. was still considering surgical options and she reported 9/10 pain. The Physician Assistant increased the Oxycontin back up to 160 mg four times per day. Respondent co-signed the note on November 6, 2003.

19. On or about December 3, 2003, B.B. reported 6/10 pain. The medications were refilled at the previous rate of 160 mg of Oxycontin four times per day and it was noted that B.B. may have a surgical procedure in March of 2004. The January 5, 2004 refill appointment contained no significant changes, but a diagnosis of myofascial pain syndrome is added to the degenerative disc disease without accompanying documentation. On or about January 26, 2004, Dr. Hunt did a trigger point injection. On or about February 6, 2003, B.B. reported that the trigger point injections helped and she had increased function with the current medication regimen.

20. In or around March of 2004 and April of 2004, B.B. reported an increase of pain to 9/10. On or about April 6, 2004, the Physician Assistant seeing B.B. determined that she should stop Oxycontin as it was ineffective for her. B.B. was instead prescribed Duragesic patches, and the Physician Assistant noted that she could start methadone on the following week if needed. B.B. continued the Norco and Baclofen. Respondent co-signed the note on April 6, 2004. On or about April 16, 2004, the Duragesic and Baclofen was increased. B.B. reported her pain at 9/10 on this visit. On or about April 28, 2004, B.B. reported the Duragesic was working much better than the Oxycontin. The Duragesic was increased and the Norco was changed to Percocet.

21. On or about May 26, 2004, B.B. reported that her pain was 9/10, and that she believed the Norco was more effective than Percocet, so she was changed back to Norco. The Duragesic patches were refilled. B.B. indicated she does not intend to try a Spinal Cord Stimulator any longer, although subsequent chart notes indicate that one was eventually placed. She indicated she was considering back surgery instead with a group of surgeons in Florida. The Physician Assistant signed the note and Respondent co-signed it on or about May 27, 2004.

22. Between June and August, B.B. was seen for refill appointment for Duragesic patches, Norco and Baclofen. She was given a trial of Klonopin for muscle spasms. During this summer she occasionally reported lower than usual pain scores. But on or about September 3, 2004, B.B. reported her pain at 10/10. The chart note indicated that although B.B. was a poor historian, she seemed to have had an appointment with a surgeon at U.C. Davis who suggested she obtain a second opinion. This caused her to see another doctor who did radiologic examinations which showed severe spinal problem and recommended she follow up with H&H for procedures. The provider noted that H&H had not received any reports from other providers as to this radiological finding, but that the provider will look into it. There do not appear to be any records from outside providers in the medical record to correlate with the September 3, 2004 chart note. On or about September 8, 2004, H&H performed a nerve block on B.B. under fluoroscopy. She reported some decrease in pain from procedure.

23. On or about September 15, 2004, B.B. reported her pain at 8/10. She reported her pain was not well controlled with the current medication regimen. In the past, she found Oxycontin very helpful, but stated she stopped it due to "negative press" about the drug and the concern she would become addicted to it. The provider reported having had a long conversation with B.B., after which she agreed to re-try Oxycontin at low dose and to discontinue the Duragesic patches. She was restarted on Oxycontin, and continued Klonopin and Baclofen. The provider did not sign this note, but it is co-signed by Respondent on or about September 16, 2004.

24. On or about September 21, 2004, the Oxycontin was increased to 80 mg 3 times day. B.B. reported increased pain and stated that the U.C. Davis physician believed it was due to hardware in her back from previous surgeries and has recommended removing it. On or about

October 5, 2004, B.B. had her medications refilled with the Oxycontin increased to 160 mg three times per day, and the Klonopin, Baclofen and Norco were continued. B.B. indicated she was scheduled for surgery to remove hardware. On or about November 2, 2004, B.B. saw Respondent and reported the hardware was removed, which has only increased her pain. B.B. stated she was now considering having surgery with a group of surgeons in Florida. The Norco was discontinued and Dilaudid was tried, 2 mg 6 times per day. Her Klonopin, Oxycontin and Baclofen were refilled.

25. On or about November 23, 2004, B.B. saw a Physician Assistant with increased complaints of pain at 9/10. The Physician Assistant noted "consulted with Dr. Hendrickson, patient on max doses of Dilaudid and Oxycontin, trial Medrol pack." On or about December 22, 2004, B.B. had another nerve block under fluoroscopy. On or about December 30, 2004, B.B. saw Respondent again and stated that she was going out of town to Florida for minimally invasive spine surgery. She indicated that she would be gone for about six weeks. Respondent wrote "will give her 240 tablets of Oxycontin to cover her for the six weeks. Will change Dilaudid to Norco as the patient states that the Norco is just as effective."

26. On or about February 17, 2005, B.B. saw Respondent again, reporting that her pain was 3/10. B.B. reported having had procedures on January 14, 2005 and January 23, 2005, which gave her great pain relief. There were no corresponding surgical reports in the record. B.B. stated she wanted to titrate down or off medication. Respondent wrote that he would change B.B. to Methadone 40 mg three times per day. On or about February 24, 2005, a telephone message indicated that B.B. reported urinary incontinence. Respondent instructed her it may be due to Methadone and to use Oxycontin instead, which they would then titrate down over time.

27. On or about February 28, 2005, B.B. was seen by a Physician Assistant who continued the plan to remain on Oxycontin until weaned down. The Baclofen and Norco were refilled. On or about March 14, 2005, B.B. reported pain at 3/10. She went from Norco to Percocet because she reported the Norco was not effective. She remained on Oxycontin with the plan still stating that she would be titrated down. On or about March 29, 2005, B.B. had a steroid injection under fluoroscopy with H&H. On or about April 11, 2005, B.B. stated she was now

down to 80 mg of Oxycontin 4 times per day. Her Percocet was refilled, and she was recommended to try aqua therapy.

28. On or about May 9, 2005, B.B. received refills and a June 5, 2005 appointment note shows she had another nerve block, but she reported increased pain. The Oxycontin was increased by one pill per day. An x-ray was ordered which showed post surgical changes and progressive disc degeneration. On or about July 5, 2005, B.B. reported increased pain and was noted to be tearful and frustrated at her last several appointments. The Physician Assistant encouraged B.B. to seek psychological counseling. Her Oxycontin was increased to 6 per day. The Baclofen and Percocet were refilled. On August 1, 2005, she had another refill appointment. During 2005, the diagnosis of myofascial pain syndrome was removed from B.B.'s record, and a new diagnosis of post laminectomy syndrome replaced it. There are no corresponding notes to explain the change.

29. On or about August 29, 2005, B.B. remained on the same medication regimen and continued to report high pain scores of 8/10 pain. She told the provider that her primary care physician is doing a work up on her for hypertension. On or about September 26, 2005, she was noted not to have obtained outside psychological counseling as recommended, but was still depressed. The H&H provider prescribed Cymbalta. B.B.'s other pain medications remained the same, and she reported that she was being treated by cardiology for hypertension.

30. In or around October of 2005, B.B. continued to report pain and depression. She indicated that she did not want to see a psychological counselor. The Cymbalta was increased. B.B. also reported that she had renal problems that were being treated by U.C. Davis. The Percocet prescription was increased and the Oxycontin and Baclofen were refilled. B.B. stated she was seeking another surgical evaluation for her back pain.

31. On or about November 21, 2005, B.B. was referred for a surgical evaluation of hardware problems from her previous back surgeries. She reported that she stopped the Cymbalta on her own because she felt it caused her to become itchy. The Percocet, Oxycontin and Baclofen were refilled. On or about December 19, 2005, B.B. reported 9/10 back pain. She stated that she

was having dental surgery done that month. Her medications were refilled. On or about January 6, 2006, the chart notes state that B.B. had a consultation with another surgeon and the report would be sent to H&H. B.B. reported 9/10 pain. Her pain medications were refilled and Cymbalta was also prescribed without accompanying documentation.

32. On or about January 23, 2006, B.B.'s lumbar MRI showed post-surgical changes, possible disc fragments interfering with spinal function. She was seen again at H&H on February 13, 2006, reporting 8/10 pain and had medications refilled. On or about March 13, 2006, B.B. reported that she was awaiting a surgery date. She reported 10/10 pain, and medications were refilled. The chart noted indicated that B.B. reported that she would have a gallstone procedure that month.

33. The chart notes indicated that B.B. had another back surgery on or about April 5, 2006, and that her next appointment at H&H was on May 9, 2006. She reported 7/10 pain. The Oxycontin, Percocet and Baclofen were refilled, although there is no surgical record of the April procedure present in the record. Chart notes indicate follow up appointment in June and July of 2006, with refills. The July 3, 2006 appointment note is not signed, but it is co-signed by Respondent on July 10, 2006. B.B. reported 9/10 pain, and the notes under the heading treatment plan state that B.B. and her husband agree that after five years of opiate medications she has developed tolerance and the medications are no longer working. They decide to try an opiate rotation of 10 mg Methadone taking one to two tablets three times per day. The notes indicate that the purpose of methadone was explained to B.B. and it was explained that she may experience withdrawal symptoms. The Baclofen and Percocet were refilled. B.B. was instructed to return in one week.

34. On or about July 10, 2006, B.B. was reportedly very angry at her appointment. B.B. stated she had 9/10 pain and was unable to contact H&H quickly enough to obtain relief from withdrawals she experienced. The notes indicate that B.B. had increased the methadone to 30 mg three times per day. And that she was instructed to increase it to 40 mg three times per day. She was also instructed to take Percocet for breakthrough pain. At the July 17, 2006, appointment B.B. reported having 10/10 pain. The note stated that she continued to be stable on

Methadone and that it provided the same relief as Oxycontin. She continued on Methadone with Percocet for breakthrough pain.

35. On or about July 24, 2006, B.B. reported 10/10 pain and said the Methadone was not helping. She returned to Oxycontin, and it was noted they would consider a trial of Kadian in the future. She was also started on Lyrica.

36. On or about August 7, 2006, B.B. continued to report high pain levels and stated that she stopped taking Lyrica. The chart notes show that an unnamed H&H provider recommended trying a pain pump. B.B. was prescribed Oxycontin at 160 mg three times per day. On or about September 11, 2006, B.B. again reported 10/10 pain and received refills.

37. On or about October 11, 2006, B.B. saw Respondent, who refilled the medications. Respondent recorded that B.B. reported that she would be seen at U.C. Davis for a trial of an intrathecal pain pump. At the November 9, 2006, appointment B.B. was seen by Dr. Hunt. He noted she reported a 10/10 pain level, which was minimally controlled with current medication and that she would see a neurologist at U.C. Davis for possible implantation of a pain pump.

38. On or about November 22, 2006, B.B. saw Respondent, still reporting a pain level of 10/10. Respondent continued B.B. on Percocet and prescribed her 160 mg Oxycontin four times per day. On or about January 2, 2007, B.B. again reported 10/10 pain. At this visit, B.B.'s blood pressure was very high. The medical record shows that B.B. had high blood pressure at several visits over the years. The Oxycontin, Baclofen and Percocet were refilled at this appointment and monthly through February. There was an Opioid Consent Agreement present in the medical record, signed by B.B. on January 2, 2007.

39. On or about March 26, 2007, B.B. reported 9/10 pain, and the record stated that B.B. would be tried on Opana and Lyrica. On or about April 2, 2007, B.B. reported that she did not tolerate the Opana, and would try Kadian instead. The note is co-signed by Dr. Hunt. On or about April 5, 2007, Dr. Hunt saw B.B. who reported pain at 10/10, and the Kadian was increased, with the Percocet continued. On or about April 9, 2007, the Kadian was increased to 150 mg twice a day, and on or about April 17, 2007, it was again increased to 200 mg twice per day.

40. On or about April 18, 2007, there was a note in B.B.'s record stating that a previous toxicology report showed the absence of any illicit drugs, but also that none of the controlled drugs B.B. was prescribed were detected either. The note stated that B.B. would have to repeat the toxicology test.

41. The next time B.B. was seen in H&H, she was seen by a Physician Assistant, on April 26, 2007, and reported her pain as 10/10. She stated that even with the 200 mg of Kadian the pain was unbearable. She was switched off Kadian and returned to Oxycontin 160 mg four times per day. The Physician Assistant noted having spoken with Respondent who stated that the practice had exhausted all the options for B.B. B.B. was continued on current medications. There was no reference to the inconsistent toxicology screening, and there was no indication that a repeat screen was performed. Respondent co-signed the note on or about May 10, 2007.

42. B.B. was seen by Respondent on or about May 21, 2007. The chart notes contain no reference of the inconsistent toxicology report. The chart notes contain template language, which is repeated throughout the records that the patient is stable on current medications with increased function. The current medical regimen allowed the patient to increase her overall daily function, and without the current medical regimen the patient would not be able to continue with her current activity level. There was also a template paragraph stating that the benefits and risks of opioid/prescribed medication, including death, had been explained to the patient who had a full understanding of the medications prescribed and agreed to proceed with medical management, with all questions answered.

43. Throughout the rest of 2007, B.B. returned to the practice approximately each month, reporting high pain levels. The diagnoses continued to be post laminectomy syndrome and lumbar degenerative disc disease. There are references to outside attempts at interventions from other providers such as trials of pain pumps, and possible surgical interventions. On or about July 30, 2007, the Percocet was stopped and replaced with Oxy IR, 5 mg four times per day. This was increased to six times per day as of December of 2007. H&H provided various physical medicine interventions during 2007 and the beginning of 2008, such as nerve blocks, lumbar ablations which B.B. reported did not improve her pain. On or about January 31, 2008,

the Oxy IR was increased by an additional two tablets per day. On or about February 28, 2008, Norco was added to the Oxy IR for breakthrough pain, and the Oxycontin dose remained the same. The same paragraphs concerning the medications allowing increased activity and the risks having been explained continue to be present in each chart note.

44. B.B. continued into 2008 to return for monthly refill appointment, frequently reporting 10/10 pain levels. On June 18, 2008, B.B. saw a nurse practitioner and reported having a trial of a Spinal Cord Stimulator with a provider in San Francisco. She reported her pain level was 10/10 and received refills. On or about June 20, 2008, B.B.'s toxicology test was positive for morphine and hydromorphone, although no provider at H&H had prescribed morphine. On or about July 15, 2008, B.B. called into H&H to ask for an earlier appointment as she would be going out of state to visit a sick brother. Respondent provided a 30 day prescription for Oxycontin. The Medical Assistant who answered the call asked B.B. about the positive morphine result. B.B. stated that her physician in San Francisco gave her a morphine injection when placing leads on the spinal cord stimulator. The Medical Assistant noted that she would inform Respondent.

45. On or about August 12, 2008, B.B. was seen again and provided with refills of Oxycontin and Norco. She told the provider that her brother was doing better. The provider noted that her June 2008 toxicology report was positive for morphine, and this was during the time she was trialing the spinal cord stimulator. B.B. reported 10/10 pain and stated that the spinal cord stimulator did not help. At this appointment, the Oxy IR is listed as "stopped" although no reference is made to it in the notes. B.B. was seen again on or about September 16, 2008, and her Oxcontin and Norco were refilled. She reported her pain level at 10/10.

46. B.B. saw Respondent on or about October 14, 2008, reporting pain at 8/10 to 9/10. Respondent continued the refills of Oxycontin and Norco. In or around November of 2008 she saw Dr. Hunt who provided the refills of Norco and Oxycontin. In or around December of 2008, B.B. had high blood pressure, which was not addressed and received refills. She had another refill appointment on January 6, 2009. A January 9, 2009 toxicology result showed B.B. was positive for oxymorphone and oxycodone, but negative for hydrocodone, despite being prescribed

Norco. On or about February 3, 2009 B.B. saw a Physician Assistant, reporting 10/10 pain level and received refills on Norco and Oxycontin. There was no reference to the toxicology report in this chart note, which Respondent co-signed on February 2, 2009. Chart notes were similar and co-signed by Respondent in March and April.

47. On or about May 28, 2009, the provider refilled Norco, Oxycontin and Motrin. The provider noted that the Baclofen was not helping B.B.'s muscle spasms. The provider ordered a random toxicology screening. A June 12, 2009, toxicology report showed that B.B. was positive for hydrocodone, hydromorphone, oxycodone and oxymorphone. The record indicated a need to follow up with B.B. at her next appointment. But at B.B.'s next appointment on June 25, 2009, there was no reference to the toxicology report. B.B. reported pain at 9/10 and medications were refilled. The July 23, 2009, appointment record was similar. At the July appointment, B.B. reported starting physical therapy. Although there was no reference to it in the treatment plan, Soma started to appear on her list of medications at 250 mg four times per day beginning on this date.

48. On or about August 20, 2009, B.B. reported her pain at 8/10 and Norco, Soma and Oxycontin were refilled. It is noted that B.B. was also seeing a chiropractor. On or about September 18, 2009, B.B. reported 8/10 pain. She stated that she was improving and doing physical therapy exercises. The Physician Assistant noted that she stopped the Soma and was trying to decrease the Oxycontin to 6 tablets per day. On or about October 16, 2009, B.B. reported 8/10 pain and stated she thought physical therapy was helpful. B.B. reported that the Oxycontin was controlling her pain. The provider ordered a toxicology screening. The Toxicology report was negative for Soma metabolites, but positive for oxycodone. On or about November 13, 2009, the Physician Assistant noted that the toxicology screening was within normal limits. He refilled Norco, Oxycontin and Soma. Neurontin was added. On or about December 11, 2009, the medications were refilled except that Neurontin was stopped. Exercise was encouraged. On or about January 8, 2010, B.B. reported pain at 9/10, and indicated that she was hospitalized for a week for treatment of kidney stones. The Oxycontin was refilled. On or about February 3, 2010, Norco, Oxycontin, Soma, Neurontin and Motrin were refilled. On or

about March 2, 2010, a toxicology screening was ordered. The March 16, 2010, toxicology results were positive for morphine. On or about April 6, 2010, there was no documentation of positive morphine result.

49. B.B. was seen by Respondent on or about May 11, 2010. He refilled Oxycontin, Norco and Soma. He did not document any reference to the toxicology report. In June and July B.B. returned and received refills. She was seen on or about August 11, 2010, at which she received refills of Norco, Soma and Oxycontin. An August 20, 2010 toxicology report showed that B.B. was positive for metabolites of Soma and Oxycontin, but negative for hydrocodone, despite being prescribed Norco and was again positive for morphine. The chart noted only that B.B. took Norco as needed.

50. On or about September 9, 2010, Respondent saw B.B., who reported 9/10 pain, and he refilled the Oxycontin. He did not document any reference to the positive morphine result. The paragraphs referencing increasing function and informing patient of risks of medications are included. During the fall of 2010, B.B. was seen monthly for refill appointments, receiving Norco, Soma, and Oxycontin. She had been reporting, and continued to report in October, that the medications are causing her constipation. In or around December 2010, the provider ordered a toxicology screening be done.

51. On or about December 23, 2010, B.B.'s toxicology result was again positive for morphine, but B.B. denied taking morphine. The note states "A PAR has been ordered for this patient. Patient's PAR report was uneventful and through research with the lab this appears to be a false negative." On or about January 12, 2011, B.B. was seen by a Physician Assistant who refilled the Oxycontin and ordered another toxicology screening.

52. On or about January 27, 2011 the toxicology report again showed positive for morphine. On or about February 14, 2011, Dr. Hunt saw B.B., who reported 8/10 pain. The note states "Patient has positive MS on tox screen. Dr. Hendrickson knows this patient well, and has reviewed the results. She will follow up with him next month." He refilled the Oxycontin.

53. On or about March 15, 2011, Respondent saw B.B. She reported 7/10 pain. Under treatment plan, the note states "The patient stated that she eats poppy seeds on a daily basis and

this is a possible reason for possible positive MS on tox screen." Respondent refilled the Soma, Oxycontin, and Norco.

54. In the Spring of 2011, B.B. continued to be seen by Physician Assistants who refilled the Oxycontin and instructed her to continue with the Norco and Soma. On or about May 20, 2011, B.B.'s toxicology results showed negative for metabolites of Soma, and Norco, and negative for hydromorphone, but positive for oxycodone and oxymorphone.

55. On or about June 8, 2011, B.B. was seen by a Physician Assistant, reporting an 8/10 pain level. The note stated B.B. is taking Soma and Norco very infrequently which explained the last toxicology results. The Oxycontin, Norco and Soma were refilled. Respondent co-signed the note on June 13, 2011. B.B. was seen again at H&H in July of 2011, with Oxycontin, Norco, and Soma refilled. On or about July 15, 2011, B.B. called to schedule an earlier appointment because she intended to travel out of state. The Medical Assistant explained that medications could not be refilled earlier than scheduled and that prescriptions would state that they were not to be filled until the next scheduled date. B.B. stated she was not attempting to obtain an early refill. On or about July 25, 2011, B.B. was seen and reported 9/10 pain. The provider noted that she took her medications as prescribed without side effects and stated "she was given one advanced prescription." The provider did not sign the note, but it is co-signed by Respondent. B.B.'s blood pressure was 159/93, and her pulse was 71.

56. On or about August 31, 2011, B.B. returned and saw the Physician Assistant. She reported she had a myocardial infarction on August 8, 2011 and was hospitalized for a week for an angioplasty. She reported 6/10 pain. In addition to the template paragraphs regarding informed consent and activity goal, the treatment notes indicate that "the medications were reviewed and renewed as before, no changes were made. The patient feels they help to maintain a more active lifestyle, including activities of daily living, with less pain. There is no adverse effects reported today." Exercise and stretching were recommended.

57. On or about September 28, 2011, B.B.'s medications were refilled. On or about October 26, 2011, B.B. reported that she was admitted to U.C. Davis for congestive heart failure

approximately 2 weeks prior, and that she was being managed with medications and would call with an updated medication list. The Oxycontin was refilled.

58. B.B. appeared for another refill of Oxycontin and Norco on or about November 22, 2011 and December 20, 2011. At the end of 2011, the diagnosis of degenerative disc disease was replaced with idiopathic scoliosis, although there was no corresponding supporting documentation or history and physical. The post laminectomy syndrome diagnosis remained. On or about January 18, 2012, the medication list stated that Soma was discontinued, although it is not referenced in the notes of any of the previous several appointments. Also at the January 2012 appointment, B.B. reported 10/10 pain and was tearful regarding her constant pain. She stated she has enough Norco for the month, but the Oxycontin was refilled. She reported new hip pain, and was recommended to raise that with her primary care physician.

59. On or about February 21, 2012, B.B. continued to report increased pain. Her medications were refilled. There is an updated opioid consent form signed by B.B. in the record, dated February 21, 2012. On or about March 20, 2012, B.B. reported a 9/10 pain level and was again started on Neurontin. She was scheduled for a random toxicology screen. The toxicology screening was positive for oxycodone but negative for opiates. It was sent for confirmation which was positive for Oxycodone and Oxymorphone only.

60. On or about April 17, 2012, B.B. reported 8/10 pain and stated that she was unable to tolerate Neurontin and stopped it after four or five days. The Oxycontin was refilled, and alternative pain management strategies such as mindfulness and relaxation techniques were reportedly discussed. On or about May 18, 2012 B.B. reported a pain level of 9/10, and the note stated that she was oriented with no obvious signs of CNS depression. The provider indicated that she had not had nerve blocks attempted for a long time and did not recall how successful they were in the past, so it would be appropriate to try them again. Her Oxycontin was refilled. At this point B.B. had been on the same Oxycontin dose of 160 mg, four times per day, for years. She reported that she was scheduled for a rectal prolapse repair in two weeks. On or about June 19, 2010, Respondent performed a nerve block with steroid injection under fluoroscopy and conscious sedation.

61. On or about July 23, 2012, B.B. saw Physician Assistant T.W. for the first time at H&H. On or about July 23, 2012, B.B. reported having a prolapse repair with partial colectomy on July 12, 2012. Ms. T.W. refilled the Oxycontin. There was no direct contact between Respondent and B.B. after July 23, 2012 when Ms. T.W. assumed her care. However, Respondent stated that he supervised and approved all the actions Ms. T.W. took with regard to patient B.B., from July 23, 2012, up through and including her discharge from the practice on May 7, 2014. Respondent had a Delegation of Services Agreement (DSA) with Ms. T.W., listing him as a physician supervisor for her. The DSA does not contain specific controlled substances or a formulary for controlled substances to be relayed as drug orders under his supervision. During his interview with the Medical Board, Respondent acknowledged that H&H had no written formulary of controlled substances that Physician Assistants can relay orders for in the practice.

62. On or about August 20, 2012, Ms. T.W. refilled the Oxycontin, and Norco. B.B. reported a pain level of 9/10. B.B. reported that she could not tolerate Neurontin, so Ms. T.W. prescribed Lyrica for neuropathic pain.

63. A Medical Assistant entered a note indicating that a toxicology screen ordered at the August appointment was positive for Opiates and Oxycontin and that B.B. was prescribed Norco, but further stated that there was no need for a confirmatory analysis. On or about September 19, 2012, B.B. again saw Ms. T.W., reporting 8/10 pain. B.B. stated she had difficulty with the Lyrica but would continue taking it. Lyrica and Oxycontin were refilled.

64. On or about October 17, 2012, Ms. T.W. refilled Oxycontin and prescribed a Lidoderm patch. B.B.'s weight dropped to 101 pounds, and she reported 9/10 pain. She further stated that she discontinued the Lyrica on her own. Her blood pressure was recorded as high. Ms. T.W. continued to refill the Oxycontin which remained at 160 mg four times per day as it has remained for several years.

65. On or about November 13, 2012, the medical software changed, but the notes continue to contain the two template paragraphs stating that the patient is stable on current medications, with increased function and that all benefits and risks of medication have been

discussed and understood. These chart notes were not co-signed by Respondent. B.B.'s Oxycontin prescriptions continued to be refilled at the same level each month, as well as Norco prescriptions, with pain levels usually reported at 8/10 or 9/10. Actual prescriptions to B.B. from H&H, however, were often issued in much higher numbers of pills than she was instructed to take. On or about December 19, 2012, B.B. reported pelvic pain, and Ms. T.W. recommended that she follow up with her primary care physician. These similar template chart notes with similar prescription orders continued during January and February of 2013. At the February appointment, B.B. told Ms. T.W. that she had stopped the Lidoderm patches. B.B. also reported having frequent and urgent bowel movements affecting her activity level and depression.

66. On or about March 27, 2013, B.B. again reported her pain level at 9/10, and stated that the frequent and urgent bowel movements continued. She stated she had a spinal cord stimulator that did not help with the pelvic pain, which she thinks stopped working following straining after a bowel movement several years ago.

67. On or about April 25, 2013, the formatting of the medical records changed again. From this point on, Ms. T.W. reported that B.B. had never smoked, in contradiction to her initial history and physical at H&H, which reported a 25-year smoking history. On or about April 25, 2013, B.B. reported a pain level of 9/10, and stated that she fell and hit her head on a glass table a week earlier which had reduced hearing and vision. Ms. T.W. told B.B. to report to the Emergency Room or urgent care immediately as she may have suffered a subdural hematoma. The note still contains the template paragraphs that the medication prescribed allowed greater function than without it, and that all risks of medications are explained and understood. Ms. T.W. refilled the Oxycontin and Norco. The instructions in the chart notes to B.B. are that she should take Oxycontin both around the clock as needed.

68. On or about May 30, 2013, B.B. reported a pain level of 9/10. Ms. T.W. listed diagnoses of post laminectomy syndrome, and periostitis without osteomyelitis, and pain in joint involving pelvic region and thigh. There was no specific history and physical documentation supporting the changed diagnosis. B.B.'s blood pressure was recorded as 167/87, and was not addressed further in the note. Ms. T.W. refilled the Norco and Oxycontin. B.B. reported that she

had an MRI to rule out a hematoma following her fall and it was negative. Ms. T.W. ordered an x-ray of her hip.

69. On or about June 27, 2013, B.B. reported 8/10 pain and the Oxycontin and Norco were refilled. Ms. T.W. recommended a referral to an orthopedist for the hip, but B.B. declined it at that time. On or about July 24, 2013, the Oxycontin was refilled. B.B. reported that her primary care physician was following up with her for a possible diagnosis of rheumatoid arthritis. On or about August 28, 2013, B.B. reported 10/10 pain and her Oxycontin and Norco were refilled. A toxicology screen was ordered.

70. On or about September 28, 2013, B.B.'s pain is recorded at 10/10, and another toxicology is ordered. Ms. T.W. charted that B.B. experienced occasional somnolence from the medications, and that she did not drive with CNS depression. The Oxycontin was refilled. There are no toxicology reports in the file that relate to any toxicology screens Ms. T.W. ordered, and no references to the screening or reports in any of the medical records she signed.

71. On or about November 27, 2013, B.B. presented with 9/10 pain and reported that she would be seen at U.C. Davis for treatment of gallbladder stones and had an endoscopy scheduled. The Oxycontin and Norco were refilled. On or about January 17, 2014, the Oxycontin was refilled, and the notes continued to remain similar.

72. On or about February 14, 2014, B.B. reported memory loss issues and stated that she would follow up with her primary care physician. She further stated that she would have an endoscopic gallbladder procedure performed later that month. B.B. again reported drowsiness and constipation from the medications. The medications were refilled with no change in the regimen.

73. B.B. had gallbladder surgery at U.C. Davis, and was discharged on or about February 26, 2014. She presented to the Emergency Department on or about February 27, 2014 for an apparent overdose of Oxycontin causing low blood pressure. She was admitted due to "altered mental status," and to rule out complications from her surgery. She was diagnosed with C-Difficile and it was treated with antibiotics for sepsis. She had a repeat gallbladder procedure at U.C. Davis at the beginning of March 2014. She was admitted to the hospital U.C. Davis and

had another gallbladder surgery on or about March 7, 2014. During this hospitalization at U.C. Davis, there was a consultation note from the Pharmacy pain management specialist, dated March 3, 2014, stating that B.B. is a complex patient with acute pain secondary to cholangitis. It stated that although her at home, by mouth, opioid prescriptions per 24 hours is equivalent to 960 mg morphine per day, "currently, patient's 24 hour opioid requirement equivalent to approximately 350 mg po morphine per day. Questionable adherence to home regimen due to negative urine drug screen and current sensitivity to hydromorphone IV. Patient may benefit from adjustment of analgesic regimen." B.B. was released from U.C. Davis on or about March 14, 2014.

74. On or about March 17, 2014, B.B. presented at the Emergency Room at Mercy Folsom. She was diagnosed with hypotension most likely secondary to excessive narcotic pain/medication. The discharge summary noted that B.B. had been discharged from U.C. Davis earlier that week following gallbladder surgery and a post-surgical infection. At that point, she had reported taking 160 mg of Oxycontin four times per day and U.C. Davis reduced her to 80 mg twice per day. In an assessment and plan, it was noted that B.B. was dehydrated. The discharging physician concluded that the use of opioids probably contributed to the hypotension B.B. experienced and ordered physical therapy. He decreased the prescribed opioid dose and referred B.B. to follow up with her pain management specialist.

75. On or about March 19, 2014, B.B. had an appointment at H&H with Ms. T.W.. Ms. T.W. noted that B.B reported 10/10 pain and, "was in Mercy Folsom recently. We have received a discharge summary." B.B. stated the pain had been intolerable since her gallbladder surgery. There was a conflicting, lengthy note by Ms. T.W. She stated that B.B. had been stable on high dose Oxycontin for the previous 10 years. She further indicated that B.B.'s acute or surgical pain would be difficult to manage, and addressed issues of opioid-induced hyperalagesia. Ms. T.W. noted that Mercy Folsom had reduced the Oxycontin dose to 80 mg three times per day, but B.B.'s pain increased, so she would raise it, and make a slower titration schedule for the Oxycontin. Ms. T.W. further referred B.B. for psychological counseling. The prescribed amount of medication did not correspond to her instructions to B.B.

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76. On or about March 26, 2014, B.B.'s husband left a telephone message stating that B.B. has been experiencing cognitive impairment and mental confusion for months. He indicated that she stopped actions in mid-motion. He was concerned that the Oxycontin withdrawal may be causing the symptoms. Ms. T.W. documented having informed him that cognitive impairment was not a withdrawal symptom and that B.B. should follow up with her primary care physician for an evaluation of possible mental status changes if necessary. She further directed him to continue with the titration schedule for reducing the Oxycontin, and to return in one week.

77. On or about April 2, 2014, B.B. had an office visit with Ms. T.W. at H&H, Ms. T.W. noted that she would maintain B.B. on the same dose and not continue further titration because B.B. complained of pain. On or about April 16, 2014, Ms. T.W. noted that B.B. said she managed to decrease her dose of Oxycontin to 80 mg Q8H for the last week and she wanted to continue that because it was helping her to have improved attention. It further indicated that B.B. had some 40 mg pills left over, so Ms. T.W. directed her to continue her current regimen and that she may take the extra 40 mg if the pain became too severe and to follow up in two weeks. Again the medication directions were not clear and did not correspond to the prescribed amounts. Ms. T.W. noted that B.B. would be having ultrasounds on her lower extremities to rule out venous thrombosis and that she had begun counseling with the psychologist.

78. On or about April 30, 2014, Ms. T.W. saw B.B. who reported 10/10 pain and denied weakness or fatigue, and was "alert and awake" and had "good mental clarity." The same note also indicates, that B.B. fell asleep twice while talking to the medical assistant, and had to catch herself before falling out of the wheelchair while speaking to Ms. T.W. Further, Ms. T.W. reported that B.B. lost attention several times while speaking to her. B.B.'s family reported that she had been having excessive sleepiness and had been falling out of her wheelchair recently, hitting her head several times. As the lengthy note continues, Ms. T.W. wrote that the family was concerned B.B. may not be taking the medications as prescribed and taking more than what she was instructed. B.B. stated that she was taking the medications as prescribed. Ms. T.W. noted that she told the family that if they believed she was not taking the medications appropriately they would have to discontinue prescribing medications because that could be very dangerous. B.B.'s

husband then reported that he found a bottle of 100 tablets of 80 mg Oxycontin, unused. Ms. T.W. noted that B.B. was due for a urine screen, but did not have to urinate, and so she would do blood work instead. The notes also stated that Ms. T.W. recommended B.B. continue with further titration of the Oxycontin to 60 mg three times per day. But, there was no indication that blood work or medication change was done. Instead, there was another statement that Ms. T.W. would "hold off on prescribing medication." Ms. T.W. stated that she was concerned about the drowsiness and referred B.B. to go to the Emergency Room immediately. The note also contains the template paragraphs that the benefits and risks of opioid medication have been explained and the patient agrees to proceed with medication management, and that the patient understands and all questions have been answered, as well as the paragraph that the goal of medication is to improve function.

79. On or about April 30, 2014, after her appointment with Ms. T.W., B.B. presented to the Mercy Folsom Emergency Room. There is a complete history and physical performed stating as follows: "History of MI, Chronic back pain on high dose Oxycontin, recent dx of bilateral lower extremity DVT, referred to ER by pain specialist for frequent falls and altered mental status. Fell yesterday and hit her head. 20-years of pack per day smoking, quit 10 years ago. Limited social alcohol consumption HR 50, respiratory rate 17, BP 126/76 slightly bradycardiac. Assessment and plan: altered mental status secondary to narcotic overdose with dehydration." Among other orders, there was a request for pain management consult. She was maintained in hospital and checked to rule out CVA. She was reported to be unsure of medications she was taking, very drowsy, groggy and deconditioned, requiring a walker for ambulation.

80. B.B. was admitted to Mercy Hospital from April 30, 2014 through May 1, 2014. She was diagnosed with altered mental status and frequent falls most likely secondary to medication over use. A CT of the head was negative. The Emergency Room reduced B.B.'s Oxycontin from 80 to 40 mg three times per day, and she was seen by physical therapy.

81. On or about May 2, 2014, B.B.'s husband left a telephone message for Ms. T.W. at H&H. He stated that B.B. was discharged from Mercy Folsom and he would like to speak to Ms. T.W. because Mercy Hospital recommended a medication consultation. He stated it was an

emergency and wanted to speak to her today. A medical assistant explained that Ms. T.W. was busy and may not respond that morning. B.B.'s husband left another message that afternoon, and the medical assistant instructed the husband that based on determination made by the physician with Mercy Folsom, H&H's Medical Director would have to review B.B.'s medication regimen. The husband explained that B.B. was currently in extreme pain and asked for a prescription to make her more comfortable while waiting for an appointment.

82. There is a final chart note on May 7, 2014, reflecting an office visit with Ms. T.W. at H&H. The note states that B.B. reported having lost her Norco bottle and was currently not taking the medication. Ms. T.W. stated that she had informed B.B. that she could not continue to prescribe opioid medications "as was Dr. Hendrickson's decision because [she] experienced an adverse event while taking Oxycontin and it is unclear if she was taking the medication as prescribed." She further stated that she discussed a trial of Duragesic patches for pain. The note then indicated that when Ms. T.W. asked B.B. if she had any further questions, "the patient-provider relationship was breeched as the husband expressed his displeasure about the care [she] had received with our clinic for the past 10 years. Due to the breech in the provider-patient relationship I cannot prescribe further medications and provided the patient with a titration schedule for her Oxycontin using the remaining tablets." She stated that she provided her with a list of other pain management providers in the area.

83. During her interview with the Medical Board, Ms. T.W. explained that the "breech" referred to in the record was that B.B.'s husband lunged at her violently, causing her to fear for her safety. She stated that she conferred with the Office Manager, who is a medical assistant, and they developed the following titration schedule, which they provided to B.B. with a list of other providers in the area:

"Day 1-5 take 1 tablet by mouth once each day

Day 6-8 take 1 tablet every other day

Day 9 off medication"

84. Ms. T.W. further stated that a Durable Power of Attorney for Health Care Decisions was put in place in 2002, naming B.B.'s husband as the Power of Attorney. She stated

that in May of 2014, B.B. lacked capacity and since her husband was the Power of Attorney for B.B., and had been violent at the clinic, she could no longer see him, and consequently could not see B.B. either. The Office Manager referred B.B. to the H&H Detoxification Unit, which was located on the same premises as the pain management clinic although there was no evidence of lack of capacity at that time and she attended most appointments without him and made her own medical decisions. Ms. T.W. states that upon B.B.'s husband becoming violent toward her, she could no longer continue to see or contact B.B. because her husband was the power of attorney and she was concerned for her personal safety.

85. B.B.'s primary care physician and psychologist attempted to assist her following her discharge from H&H by finding alternate pain management care. Calls from B.B. and her psychologist to H&H requesting additional care were not returned.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)
[Bus. & Prof. Code, § 2234]

86. Respondent Jay A. Hendrickson, M.D. is subject to disciplinary action under section 2234, subsection (b), in that he was grossly negligent in his care and treatment of B.B. The circumstances are as follows:

87. Paragraphs 9 through 85 above are repeated here as if fully set forth.

88. Respondent was grossly negligent in his care and treatment of Patient B.B. for his acts including, but not limited to, the following:

a. Failing to conduct a detailed history and examination or to document this after the initial history and physical and at appropriate points in the course of B.B.'s treatment as her condition and response to interventions changed;

b. Failing to appropriately address, document and alter treatment plan and medications over the course of treatment and in response to reports of adverse effects from medications;

c. Failing to conduct periodic reassessment and documentation of the medical indications for continuing or altering medications;

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d. Failing to conduct appropriate medical management of comorbidities, or to refer for medical treatment of physical symptoms of underlying medical conditions and to coordinate care with other medical providers;

e. Providing excessive medications to B.B.;

f. Providing inconsistent and confusing directions to B.B. regarding her use of the medications being prescribed to her and providing prescriptions that contradicted the instructions to the patient on how to take the medications;

g. Allowing physician assistants to treat a complex, chronic pain patient without adequate supervision.

h. Failing to obtain meaningful informed consent for the types and changes in the medication provided to B.B.;

i. Failing to obtain consultations when appropriate and for addiction and dependence in response to signs of possible medication misuse;

j. Failing to comply with DEA and drug manufacturer guidelines for prescribing, or to document a reasonable basis to depart from these guidelines; and

k. Inappropriately terminating B.B. from care with insufficient alternative access to care and follow up.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)
[Bus. & Prof. Code, § 2234]

89. Respondent Jay A. Hendrickson, M.D. is subject to disciplinary action under section 2234, subsection (c), in that he committed repeated negligent acts in his care and treatment of B.B. The circumstances are as follows:

90. Paragraphs 9 through 85 above are repeated here as if fully set forth.

91. Respondent was repeatedly negligent in his care and treatment of Patient B.B. for his acts including, but not limited to, the following:

a. Failing to conduct a detailed history and examination or to document this after the initial history and physical and at appropriate points in the course of B.B.'s treatment as her condition and response to interventions changed;

b. Failing to appropriately address, document and alter treatment plan and medications over the course of treatment and in response to reports of adverse effects from medications;

c. Failing to conduct periodic reassessment and documentation of the medical indications for continuing or altering medications;

d. Failing to conduct appropriate medical management of comorbidities, or to refer for medical treatment of physical symptoms of underlying medical conditions and to coordinate care with other medical providers;

e. Providing excessive medications to B.B.;

f. Providing inconsistent and confusing directions to B.B. regarding her use of the medications being prescribed to her and providing prescriptions that contradicted the instructions to the patient on how to take the medications;

g. Allowing physician assistants to treat a complex, chronic pain patient without adequate supervision.

h. Failing to obtain meaningful informed consent for the types and changes in the medication provided to B.B.;

i. Failing to obtain consultations when appropriate and for addiction and dependence in response to signs of possible medication misuse;

j. Failing to comply with DEA and drug manufacturer guidelines for prescribing, or to document a reasonable basis to depart from these guidelines; and

k. Inappropriately terminating B.B. from care with insufficient alternative access to care and follow up.

THIRD CAUSE FOR DISCIPLINE
[Bus. & Prof. Code, §§ 2234, 2266]
(Failing to Adequately and Accurately Maintain Medical Records)

92. Respondent Jay A. Hendrickson, M.D. has subjected his license to disciplinary action under sections 2234 and 2266 by failing to maintain adequate and accurate records relating to the provision of services to patient B.B.

93. Paragraphs 9 through 85, above are repeated here as if fully set forth.

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94. As set forth in paragraphs 9 through 85, Respondent and mid-level providers under his supervision failed to adequately and accurately document the provision of care to patient B.B., which failures include, but are not limited to, providing inconsistent and confusing instructions on taking medications, including template and inaccurate information in B.B.'s medical record such as that she never smoked, failing to address relevant diagnostic information and findings related to care and failing to adequately record histories, physicals, accurate assessments and reassessments of B.B.'s pain, medications prescribed, and outside treatment notes.

FOURTH CAUSE FOR DISCIPLINE
[Bus. & Prof. Code, §§ 2234, subd. (a), 3502]
(Failing to Properly Supervise Physician Assistant)

95. Respondent Jay A. Hendrickson, M.D. has subjected his license to disciplinary action under sections 2234, subdivision (a), and 3502, for unprofessional conduct in that he failed to properly supervise a physician assistant.

96. Paragraphs 9-85, above are restated and incorporated herein as if fully set forth.

97. Respondent allowed physician assistants to treat B.B. with minimal supervision, despite the fact that she was a complex, chronic pain patient with multiple co-morbidities and concerning medication use histories.

98. Respondent's conduct as described above constitutes unprofessional conduct in violation of section 2234, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

FIFTH CAUSE FOR DISCIPLINE
[Bus. & Prof. Code, §§ 2234, subd. (a), 3502.1]
(Failing to Establish Written Formulary for Drug Orders of Physician Assistant)

99. Respondent Jay A. Hendrickson, M.D. has subjected his license to disciplinary action under sections 2234, subdivision (a), and 3502.1, for unprofessional conduct in that he failed to establish written formulary for relaying drug orders and to include them in the Delegation of Services Agreement for the supervision of a physician assistant in his pain management practice.

100. Paragraphs 9 through 85, above, are incorporated here as if fully set forth herein.

101. Respondent did not have a written formulary and corresponding lists contained in the Delegation of Services Agreement for Physician Assistants in his practice, including Physician Assistant T.W. Without these written guidelines and formulary, he was requited to provide prior authorization for the before Ms. T.W. and the other Physician Assistants could relay drug orders for controlled substances for patient B.B. Respondent did not provide prior authorization and did not even co-sign the chart notes in which these drug orders were charted.

102. Respondent's conduct as described above constitutes unprofessional conduct in violation of section 2234, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

Patient B.H.

103. Patient B.H. was seen in H&H from 2000 through 2017.[4] Patient B.H. has a history of a motorcycle accident in 1995 with a right arm injury and a brachial plexus injury, which led to gangrene. B.H. underwent an above the elbow amputation of the right arm during 1999, which left him with chronic phantom limb pain of the right arm. B.H. had his first appointment with Respondent on or about March 31, 2000. He completed a pain contract, which contained a prohibition on B.H. using marijuana while receiving controlled substances. As of 2011, B.H. was frequently seen by mid-level practitioners including physician assistants and nurse practitioners. As of February 22, 2011, B.H. was prescribed 984 mg of Morphine Equivalent Doses daily (MED) of opioid medications from H&H. This included a 100 mcgm patch every two days, MS Contin 60 mg, two tablets three times per day, and Dilaudid 8 mg 1-2 every four hours. B.H. also received Neurontin 400 mg three times per day, and Klonopin 2 mg three at night. B.H. was seen approximately monthly.

104. Physician Assistant T.W. began seeing B.H. at H&H in approximately June of 2012, under the supervision of Respondent. Respondent failed to cosign the medical records T.W. prepared until approximately June of 2015. Respondent's Delegation of Services Agreement with T.W. does not contain written formularies or protocols for supervision. T.W.'s chart notes

[4] Facts alleged outside the statute of limitations are for informational purposes.

consisted of similar to identical language from visit to visit for history, reviews of systems, pain scores, and other facts. This language appears to be repopulating template language. The first mention in T.W.'s chart notes of B.H.'s above the elbow amputation of the right arm was not until approximately March 30, 2015. B.H. continued to receive MED of opioid medications at 984 per day during 2011, 2012, and 2013.

105. In 2014, B.H.'s chart notes indicated that practice guidelines had changed so doses were being reduced. The Dilaudid prescriptions were reduced, and B.H.'s MED went down to 792. In 2015 the Dilaudid and MS Contin was reduced leading to a MED of 612 daily.

106. During January and May of 2017, B.H. had a number of inconsistent toxicology screenings showing the presence of marijuana and the absence of certain medications prescribed. At the date of his last visit, on or about April 17, 2017, B.H. was receiving 90 MED daily, and was directed to taper the MS Contin. He was given a written schedule to do so. The chart notes did not explicitly state that the reason for the taper was due to the toxicology results.

SIXTH CAUSE FOR DISCIPLINE
(Gross Negligence)
[Bus. & Prof. Code, § 2234]

107. Respondent Jay A. Hendrickson, M.D. is subject to disciplinary action under section 2234, subsection (b), in that he was grossly negligent in his care and treatment of B.H.

108. Paragraphs 9 through 10, 61, and 103 through 106 above are repeated here as if fully set forth.

109. Respondent was grossly negligent in his care and treatment of Patient B.H. in allowing a physician assistant to treat a complex, chronic pain patient receiving high doses of opioids in excess of recommended doses without adequate supervision, providing cause for discipline to Respondent's physician's and surgeon's certificate.

SEVENTH CAUSE FOR DISCIPLINE
[Bus. & Prof. Code, §§ 2234, subd. (a), 3502]
(Failing to Properly Supervise Physician Assistant)

110. Respondent Jay A. Hendrickson, M.D. has subjected his license to disciplinary action under sections 2234, subdivision (a), and 3502, for unprofessional conduct in that he failed to properly supervise a physician assistant.

111. Paragraphs 9 through 10, 61, and 103 through 106 above are restated and incorporated herein as if fully set forth.

112. Respondent allowed physician assistants to treat B.H. with minimal supervision, despite the fact that he was a complex, chronic pain patient with multiple co-morbidities and concerning medication use histories.

113. Respondent's conduct as described above constitutes unprofessional conduct in violation of section 2234, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

EIGHTH CAUSE FOR DISCIPLINE
[Bus. & Prof. Code, §§ 2234, subd. (a), 3502]
(Failing to Establish Written Protocols of Physician Assistant)

114. Respondent Jay A. Hendrickson, M.D. has subjected his license to disciplinary action under sections 2234, subdivision (a), and 3502, for unprofessional conduct in that he failed to establish written protocols for the supervision of a physician assistant in his pain management practice.

115. Paragraphs 9 through 10, 61, and 103 through 106 above, are incorporated here as if fully set forth herein.

116. Respondent did not have written protocols for Physician Assistants in his practice, including Physician Assistant T.W. Without these written protocols, Physician Assistant T.W. treated, diagnosed, prescribed and altered medications of a high dose patient, B.H. thus presenting significant risk to the patient. T.W.'s chart notes reflected inadequate examination and management of chronic conditions, with appropriate referrals for significant changes in his status.

117. Respondent's conduct as described above constitutes unprofessional conduct in violation of section 2234, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 83722, issued to Jay A. Hendrickson, M.D.;

2. Revoking, suspending or denying approval of Jay A. Hendrickson, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Jay A. Hendrickson, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: August 28, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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